# PATIENT DATA SHEET

## General Information

First Name _____
Middle Initial _____
Last Name _____
Called Name _____
Address _____
City _____
State _____
Zip Code _____
Home Phone _____
Work Phone _____
Cell Phone _____
Pager No. _____
Email Address _____
Sex Male Female
Race American Indian, Alaska Native, Asian, Black or African America, Native Hawaiian, Other Pacific Islander, White, Declined to State
Ethnicity Declined to State, Hispanic or Latino, Not Hispanic or Latino
Language _____
Marital Status Single Married Other _____
Birthdate _____
Social Security _____
Referred By _____
Work Status Employed Full-time student Part-time student
Appt Reminder _____

## Insured's Information

Patient is the Same/Self Husband Wife Child Other of Insured
First Name _____
Middle Initial _____
Last Name _____
Address _____
City, State, Zip _____
Phone Number _____
Social Security _____
Date of Birth _____
Sex Male Female Unknown

## Carrier Information

Name/Code _____
Attn: _____
Address _____
City, State, Zip _____
Contact _____
Phone _____
Fax Number _____
Email Address _____
Web Site _____
Payer ID _____

### *For Office Use Only*

Account Number _____
Account Category_____
Type of Account 1 2 3 4 5 6 7 8 9 Z
Code Set _____
Yearly Deductible_____
Deductible Rest Date _____
Unused Deductible_____
Copay _____
Patient Percentage _____
Household Mailing Yes No
Doctor Number _____
Maximum Charges_____
Max Charge per Day _____
Maximum Visits _____
Max Visits Since Diag _____
Max Treatment Date _____
Full Balance _____
Patient Balance _____
Diagnosis Codes _____

## Coverage Information

Coverage Effective Date_____
Coverage Notes_____
Limitations Notes _____

## Plan Information

Plan Name _____
Insurance ID_____
Group No_____
Benefits Primary Secondary Other
Coordination_____
Send Form To_____
Claim Type_____

## Employer Information

Employer/Code_____
Attn: _____
Address_____
City, State, Zip_____
Contact_____
Phone_____

## Condition Information

Related to Employment Yes No
Related to Auto Accident Yes No
Related to Other Accident Yes No
Similar Symptoms_____
Consultation Date_____
Condition Date_____

## COMPANY NO. 2

### Insured's Information

Patient is the Same/Self Husband Wife Child Other of Insured
First Name _____
Middle Initial _____
Last Name _____
Address _____
City, State, Zip _____
Phone Number _____
Social Security _____
Date of Birth _____
Sex Male Female Unknown

### Plan Information

Plan Name _____
Insurance ID_____
Group No _____
Local Use _____
Benefits Primary Secondary Other
Coordination _____
Claim Type _____
Send Form To _____

### Carrier Information

Name/Code _____
Attn: _____
Address _____
City, State, Zip _____
Contact _____
Phone _____
Fax Number _____
Email Address _____
Web Site _____
Payer ID _____
Form Layout _____

### Employer Information

Employer/Code _____
Attn: _____
Address _____
City, State, Zip _____
Contact _____
Phone _____

### Coverage Information

Coverage Effective Date _____
Coverage Notes _____
Limitations Notes _____

## COMPANY NO. 3

### Insured's Information

Patient is the Same/Self Husband Wife Child Other of Insured
First Name _____
Middle Initial _____
Last Name _____
Address _____
City, State, Zip _____
Phone Number _____
Social Security _____
Date of Birth _____
Sex Male Female Unknown

### Plan Information

Plan Name _____
Insurance ID_____
Group No _____
Local Use _____
Benefits Primary Secondary Other
Coordination _____
Claim Type _____
Send Form To _____

### Carrier Information

Name/Code _____
Attn: _____
Address _____
City, State, Zip _____
Contact _____
Phone _____
Fax Number _____
Email Address _____
Web Site _____
Payer ID _____
Form Layout _____

### Employer Information

Employer/Code _____
Attn: _____
Address _____
City, State, Zip _____
Contact _____
Phone _____

### Coverage Information

Coverage Effective Date _____
Coverage Notes _____
Limitations Notes _____